"Torn Between Two Systems: Improving Chronic Care in

Medicare and Medicaid"

Opening Statement of Senator John B. Breaux, Ranking Member

Senate Special Committee on Aging

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Any serious attempt to hold down Medicare and Medicaid costs must take the needs of the dually eligible -- the elderly and disabled poor -- into account. They are the most expensive of the Medicare and Medicaid beneficiaries. They account for a disproportionately large share of spending in both Medicare and Medicaid. As 16% of the Medicare population, they account for 30% of its expenditures. As 17% of the Medicaid population, they consume 35% of its payments. Overall, $106 billion was spent in 1995 on the dual eligibles. This amounts to 9 times more money than was spent nationally on medical research.

As only 2% of the nation's population, they account for 10% of the country's health care spending. They are also the two fastest growing segments of the Medicare population. These groups-- the nonelderly disabled and individuals 85 years and older-- are the two groups most likely to be dually eligible.

The current financing and delivery of health care between the Medicare and Medicaid programs is fragmented, not cost effective, and fails to serve the beneficiaries' health needs well.

For example, Medicare, which pays for acute care, encourages hospitals to discharge the elderly quickly to nursing homes or home care facilities. Medicaid, which pays for many of the long term needs of the elderly, encourages nursing homes to discharge high cost and high service-using residents to hospitals where Medicare picks up the tab.

We will hear today about the enormous financial costs that result to taxpayers and personal costs to family members to this shifting between the two systems.

Managed care, with its integration of health care services, has enormous potential to combine both the Medicare and the Medicaid programs' funding streams and provide coordinated health care for this population.

But while the Medicare and Medicaid programs are beginning to hold down costs through managed care arrangements, the dually eligible beneficiaries are <u>not</u> participating in these plans. While 77% of workers nationwide are enrolled in managed care plans, only 3% of dually eligible individuals are enrolled. Only 7% of all Medicare HMO enrollees are dually eligible.

Traditional managed care, with its emphasis on acute care and preventative medicine, is not equipped to handle the long term and chronic care needs of this population. In addition, flat payment rates give HMO's an incentive to avoid high cost patients. The dually eligible beneficiaries-- the most expensive-- are therefore patients left behind in fee-for-service medicine, where costs are skyrocketing.

Even injecting competition into the Medicare managed care marketplace, as under the FEHBP model I have proposed, will not help reduce the costs of these needy beneficiaries enrolled in fee-for-service plans. We must focus more attention on how to adapt the cost-saving mechanisms of managed care to

the needs of our most expensive, most vulnerable citizens.

This hearing will showcase some new, innovative managed care projects that are proving it is possible to offer better health care to our seniors and save money. We will hear about ideas like case management, where a provider coordinates the health care for these seniors, making sure they are receiving the care they need, not the care Medicare or Medicaid decides it will pay for or has cost shifted to the other program.

We will hear from representatives from two states, who have developed new ways to combine Medicare and Medicaid to offer their elderly poor a wide range of health care services.

But we will also hear about problems with these arrangements. The dually eligible are not a healthy population, and they need high quality care. Per capita caps and block grants, for example, pose special problems for the dually eligible. Capping federal payments to states in Medicaid will make it extremely difficult for programs that coordinate care to exist-- they will not be able to afford it.

In fact, a per capita cap will reproduce the same negative incentives that lead HMO's which receive a flat payment and to avoid high-cost, chronically-ill people. We need to move slowly, but with an open mind and an eye for new ideas. These are our most vulnerable citizens, and we owe them the best of our nation's health care.